



AN ACT GENERALLY REVISING LAWS UNDER THE SUPERVISION OF THE STATE AUDITOR; REVISING SECURITIES LAWS RELATING TO DISCLOSURE OF FINANCIAL EXPLOITATION OF AN OLDER PERSON; AUTHORIZING THE SECURITIES ASSISTANCE RESTITUTION FUND TO ASSERT CERTAIN CLAIMS FOR RESTITUTION; REVISING LAWS RELATING TO COMMISSIONER ACCESS TO INSURANCE RECORDS; REVISING INSURANCE LAWS TO REMOVE CERTAIN SERVICE OF PROCESS FEES; REVISING INSURANCE SERVICE OF PROCESS LAWS; REVISING INSURANCE CERTIFICATE OF AUTHORITY LAWS; REQUIRING THE COMMISSIONER TO MAKE AN APPROVED RISK LIST; REVISING THE PENALTY RELATING TO CERTAIN SURPLUS LINES FILINGS; DEFINING PHARMACY SERVICES ADMINISTRATIVE ORGANIZATION; REVISING LAWS RELATING TO PHARMACY SERVICES ADMINISTRATIVE ORGANIZATIONS; REVISING LAWS RELATING TO FILINGS OF POLICY FORMS; REVISING LAWS RELATING TO THE APPOINTMENT OF FOREIGN OR ALIEN SOCIETIES; REVISING LAWS RELATING TO THE BOARD OF DIRECTORS OF THE MONTANA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION BOARD; REVISING LAWS RELATING TO COMMERCIAL LINES POLICIES; REVISING LAWS RELATING TO THE FILING OF VARIABLE LIFE INSURANCE CONTRACTS; REVISING PHARMACY SERVICES ADMINISTRATIVE ORGANIZATION LAWS; REVISING DEFINITIONS; REVISING LAWS RELATING TO THE MONTANA REINSURANCE ASSOCIATION ACT; DEFINING "TITLE GUARANTEE"; AUTHORIZING THE COMMISSIONER TO ORDER RESTITUTION RELATED TO TITLE INSURANCE; REVISING LAWS RELATING TO IN-NETWORK AND OUT-OF-NETWORK EMERGENCY SERVICES; REVISING LAWS RELATED TO UTILIZATION REVIEW ORGANIZATIONS; REVISING LAWS RELATED TO STANDARDS FOR PROPERTY AND CASUALTY INSURERS; PROVIDING FOR COVERAGE OF CERTAIN ORAL THERAPY PRESCRIPTIONS RELATED TO OPIOID USE DISORDERS; TRANSFERRING STATUTORY DUTIES FROM THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES TO THE COMMISSIONER OF SECURITIES AND INSURANCE RELATING TO THE MANAGED CARE PLAN NETWORK ADEQUACY AND QUALITY ASSURANCE ACT; AUTHORIZING THE

COMMISSIONER TO TRANSFER EXISTING RULES RELATING TO THE ACT; EXTENDING RULEMAKING AUTHORITY; AMENDING SECTIONS 15-31-114, 30-10-341, 30-10-1004, 33-1-408, 33-1-605, 33-1-1502, 33-2-116, 33-2-312, 33-2-2402, 33-2-2404, 33-4-509, 33-7-531, 33-10-204, 33-15-336, 33-17-1101, 33-20-606, 33-20-1304, 33-20-1316, 33-22-156, 33-22-170, 33-22-172, 33-22-173, 33-22-177, 33-22-1128, 33-22-1316, 33-23-310, 33-25-105, 33-25-301, 33-31-201, 33-32-215, 33-33-102, 33-33-201, 33-33-202, 33-36-102, 33-36-103, 33-36-105, 33-36-201, 33-36-203, 33-36-209, 33-36-210, 33-36-211, 33-36-212, 33-36-213, 33-36-301, 33-36-302, 33-36-303, 33-36-304, 33-36-305, AND 33-36-401, MCA; REPEALING SECTIONS 33-2-322, 33-7-123, AND 33-17-405, MCA; AND PROVIDING EFFECTIVE DATES AND AN APPLICABILITY DATE.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 15-31-114, MCA, is amended to read:

"15-31-114. Deductions allowed in computing income. (1) In computing the net income, the following deductions are allowed from the gross income received by the corporation within the year from all sources:

(a) all the ordinary and necessary expenses paid or incurred during the taxable year in the maintenance and operation of its business and properties, including reasonable allowance for salaries for personal services actually rendered, subject to the limitation contained in this section, and rentals or other payments required to be made as a condition to the continued use or possession of property to which the corporation has not taken or is not taking title or in which it has no equity. A deduction is not allowed for salaries paid upon which the recipient has not paid Montana state income tax. However, when domestic corporations are taxed on income derived from outside the state, salaries of officers paid in connection with securing the income are deductible.

(b) (i) all losses actually sustained and charged off within the year and not compensated by insurance or otherwise, including a reasonable allowance for the wear and tear and obsolescence of property used in the trade or business. The allowance is determined according to the provisions of section 167 of the Internal Revenue Code in effect with respect to the taxable year. All elections for depreciation must be the same as the elections made for federal income tax purposes. A deduction is not allowed for any amount paid

out for any buildings, permanent improvements, or betterments made to increase the value of any property or estate, and a deduction may not be made for any amount of expense of restoring property or making good the exhaustion of property for which an allowance is or has been made. A depreciation or amortization deduction is not allowed on a title plant as defined in 33-25-105(45).

(ii) There is allowed as a deduction for the taxable period a net operating loss deduction determined according to the provisions of 15-31-119.

(c) in the case of mines, other natural deposits, oil and gas wells, and timber, a reasonable allowance for depletion and for depreciation of improvements. The reasonable allowance must be determined according to the provisions of the Internal Revenue Code in effect for the taxable year. All elections made under the Internal Revenue Code with respect to capitalizing or expensing exploration and development costs and intangible drilling expenses for corporate income tax purposes must be the same as the elections made for federal income tax purposes.

(d) the amount of interest paid within the year on its indebtedness incurred in the operation of the business from which its income is derived. Interest may not be allowed as a deduction if paid on an indebtedness created for the purchase, maintenance, or improvement of property or for the conduct of business unless the income from the property or business would be taxable under this part.

(e) (i) taxes paid within the year, except the following:

(A) taxes imposed by this part;

(B) taxes assessed against local benefits of a kind tending to increase the value of the property assessed;

(C) taxes on or according to or measured by net income or profits imposed by authority of the government of the United States;

(D) taxes imposed by any other state or country upon or measured by net income or profits.

(ii) Taxes deductible under this part must be construed to include taxes imposed by any county, school district, or municipality of this state.

(f) that portion of an energy-related investment allowed as a deduction under 15-32-103;

(g) (i) except as provided in subsection (1)(g)(ii) or (1)(g)(iii), charitable contributions and gifts that qualify for deduction under section 170 of the Internal Revenue Code, 26 U.S.C. 170, as amended.

(ii) The public service commission may not allow in the rate base of a regulated corporation the inclusion of contributions made under this subsection.

(iii) A deduction is not allowed for a charitable contribution using a charitable gift annuity unless the annuity is a qualified charitable gift annuity as defined in 33-20-701.

(h) per capita livestock fees imposed pursuant to 15-24-921, 15-24-922, 81-6-104, 81-6-204, 81-6-209, 81-7-118, or 81-7-201.

(2) In lieu of the deduction allowed under subsection (1)(g), the taxpayer may deduct the fair market value, not to exceed 30% of the taxpayer's net income, of a computer or other sophisticated technological equipment or apparatus intended for use with the computer donated to an elementary, secondary, or accredited postsecondary school located in Montana if:

(a) the contribution is made no later than 5 years after the manufacture of the donated property is substantially completed;

(b) the property is not transferred by the donee in exchange for money, other property, or services; and

(c) the taxpayer receives a written statement from the donee in which the donee agrees to accept the property and representing that the use and disposition of the property will be in accordance with the provisions of subsection (2)(b).

(3) In the case of a regulated investment company or a fund of a regulated investment company, as defined in section 851(a) or 851(g) of the Internal Revenue Code of 1986, 26 U.S.C. 851(a) or 851(g), as that section may be amended or renumbered, there is allowed a deduction for dividends paid, as defined in section 561 of the Internal Revenue Code of 1986, 26 U.S.C. 561, as that section may be amended or renumbered, except that the deduction for dividends is not allowed with respect to dividends attributable to any income that is not subject to tax under this chapter when earned by the regulated investment company. For the purposes of computing the deduction for dividends paid, the provisions of sections 852(b)(7) and 855 of the Internal Revenue Code of 1986, 26 U.S.C. 852(b)(7) and 855, as those sections may be amended or renumbered, apply. A regulated investment company is not allowed a deduction for dividends received as defined in sections 243 through 245 of the Internal Revenue Code of 1986, 26 U.S.C. 243 through 245, as those sections may be amended or renumbered."

Section 2. Section 30-10-341, MCA, is amended to read:

"30-10-341. Third-party disclosure -- immunity. (1) ~~If a qualified individual, investment adviser, investment adviser representative, or salesperson reasonably believes that financial exploitation of a vulnerable person may have occurred, may have been attempted, or is being attempted, the qualified individual, investment adviser, investment adviser representative, or salesperson may notify any third party closely connected to the vulnerable person. Disclosure may not be made to a third party who is suspected of financial exploitation or other abuse of the vulnerable person~~ A qualified individual, investment adviser, investment adviser representative, or salesperson who reasonably believes that the financial exploitation of a vulnerable person is occurring, has or may have occurred, is being attempted, or has been or may have been attempted:

(a) may notify:

(i) a federal, state, or local law enforcement agency;

(ii) the department of public health and human services provided for in 2-15-2201 or its local affiliate; or

(iii) the commissioner;

(b) may notify any third party reasonably associated with a vulnerable person. A third party reasonably associated with a vulnerable person includes but is not limited to the following:

(i) a parent, spouse, adult child, sibling, or other known family member or close associate of a vulnerable person;

(ii) an authorized contact provided by a vulnerable person to the qualified individual, investment adviser, investment adviser representative, or salesperson;

(iii) a co-owner, additional authorized signatory, or beneficiary of a vulnerable person's account;

and

(iv) an attorney-in-fact, trustee, conservator, guardian, or other fiduciary who has been selected by a vulnerable person, a court, a government agency, or a third party to manage some or all of the financial affairs of the vulnerable person;

(c) may not notify any third party reasonably associated with a vulnerable person of suspected financial exploitation if the qualified individual, investment adviser, investment adviser representative or

salesperson believes the third party is, may be, or may have been engaged in the financial exploitation of the vulnerable person.

(2) A qualified individual, investment adviser, investment adviser representative, or salesperson who, in good faith and exercising reasonable care, complies with this section is immune from administrative or civil liability that might otherwise arise from the disclosure."

Section 3. Section 30-10-1004, MCA, is amended to read:

"30-10-1004. (Temporary) Creation of securities restitution assistance fund. (1) There is an account in the state special revenue fund to the credit of the commissioner for use only for securities restitution assistance. This account may be referred to as the "securities restitution assistance fund" or "fund". The money in the fund is statutorily appropriated, as provided in 17-7-502, to the commissioner for the purposes provided in subsection (4) of this section.

(2) (a) The fund consists of amounts received by the commissioner from:

- (i) persons who have violated any provision of parts 1 through 3 of this chapter;
- (ii) persons who have voluntarily contributed to the fund; and
- (iii) a portion of fees collected under 30-10-209(1)(b) as provided in 30-10-209(6)(b).

(b) Amounts received by the commissioner for deposit in the fund do not include administrative penalties or fines imposed under this chapter and as referenced under the Montana Administrative Procedure Act, Title 2, chapter 4, part 6.

(c) The amounts received for the fund may not be placed in the general fund.

(3) Amounts received by the commissioner for deposit in the fund must be promptly turned over to the state treasurer for deposit in the fund created under subsection (1).

(4) The fund may be used by the commissioner only to pay awards of restitution assistance under this part.

(5) Whenever a claimant is paid from the securities restitution assistance fund pursuant to this part, the securities restitution assistance fund is subrogated, to the extent of the payment to the claimant, to the rights of the claimant to any restitution ordered by the court beyond the amount that would make the claimant whole. The commissioner may, on behalf of the securities restitution assistance fund, file any document in a

court of competent jurisdiction to enforce this right. (Terminates June 30, 2027--secs. 3, 4, Ch. 404, L. 2021.)"

Section 4. Section 33-1-408, MCA, is amended to read:

"33-1-408. Conduct of examinations -- records -- correction of accounts -- appraisals. (1) Upon determining that an examination should be conducted, the commissioner or the commissioner's designee shall issue an examination warrant appointing one or more examiners to perform the examination and instructing them as to the scope of the examination. In conducting the examination, an examiner shall observe the guidelines and procedures set forth in the examiners' handbook adopted by the NAIC. The commissioner may also employ other guidelines or procedures as the commissioner considers appropriate.

(2) Every company or person from whom information is sought and its officers, directors, employees, and agents shall provide to the examiners appointed under subsection (1) timely, convenient, and free access at all reasonable hours ~~at its offices~~ to all books, records, accounts, papers, documents, and any or all computer or other recordings relating to the property, assets, business, and affairs of the company being examined, including but not limited to access at its offices. The officers, directors, employees, and agents of the company or person shall facilitate the examination and aid in the examination so far as it is in their power to do so. The refusal of any company, by its officers, directors, employees, or agents, to submit to examination or to comply with any reasonable written request of the examiners is grounds for suspension, refusal, or nonrenewal of any license or authority held by the company to engage in an insurance or other business subject to the commissioner's jurisdiction. A proceeding for suspension, revocation, or refusal of any license or authority must be conducted pursuant to 33-1-318 and 33-1-701.

(3) The commissioner or any examiner has the power to issue subpoenas, administer oaths, and examine under oath any person concerning any matter pertinent to the examination. Upon the failure or refusal of a person to obey a subpoena, the commissioner may petition a court of competent jurisdiction and, upon proper showing, the court may enter an order compelling the witness to appear and testify or to produce documentary evidence. Failure to obey the court order is punishable as contempt of court.

(4) When making an examination under this part, the commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals and specialists as examiners. The cost of retaining the personnel must be borne by the company that is the subject

of the examination.

(5) This part may not be construed to limit the commissioner's authority to terminate or suspend any examination in order to pursue other legal or regulatory action pursuant to this title. Findings of fact and conclusions made pursuant to an examination are prima facie evidence in any legal or regulatory action.

(6) This part may not be construed to limit the commissioner's authority to use and, if appropriate, to make public any final or preliminary examination report, any examiner or company workpapers or other documents, or any other information discovered or developed during the course of any examination in the furtherance of any legal or regulatory action that the commissioner may consider appropriate."

Section 5. Section 33-1-605, MCA, is amended to read:

"33-1-605. Service of process -- foreign or alien insurer -- appointment of registered agent. (1)

A foreign or alien insurer that transacts any business in this state must have a registered agent upon whom any legal process, notice, or demand required or permitted by law to be served upon a company must be served. The agent must be a person who either resides or maintains a business address in this state.

(2) The written appointment of an agent must be provided to the commissioner in a form prescribed by the commissioner, and must, at minimum, include a consent to service of process and the official name and address of the agent and the insurer represented.

(3) The commissioner shall keep a record of the foreign and alien insurers transacting business in Montana and the name and address of their registered agents. This record must be made public in a readily accessible form prescribed by the commissioner.

(4) Service by certified mail to a registered agent listed for an insurer constitutes service of legal process upon that insurer.

(5) An insurer may revoke the appointment of an agent by filing with the commissioner a written appointment of another agent and a statement that the appointment of the former agent is revoked. The authority of the agent whose appointment has been revoked terminates 30 days after the notice is received by the commissioner.

(6) When a foreign or alien insurer ceases to do business in this state, the agent last designated by or acting for the insurer is deemed to continue as agent for it unless a new agent is appointed. Service by

certified mail upon any such agent constitutes service of legal process upon the insurer.

~~(7)~~ Each insurer shall include a fee of \$10 with any initial appointment, change of agent appointment, or change of address. The fee is waived for an insurer filing an agent appointment with an original application for a certificate of authority or an annual renewal.

~~(8)~~(7) This section does not limit or affect the right to serve any process, notice, or demand upon an insurer in any other manner permitted by law.

~~(9)~~(8) When legal process is served pursuant to this section, the insurer must appear, answer, or plead within 30 days, exclusive of the date of mailing, after the date of the certified mailing or be subject to the laws of this state regarding default judgment.

~~(10)~~(9) For the purposes of this section:

- (a) "certified mail" means a method of sending by common carrier with tracking capability; and
- (b) "legal process" means a summons and complaint."

Section 6. Section 33-1-1502, MCA, is amended to read:

"33-1-1502. Application of criminal law and procedure. (1) Unless a rule or statute specifically states otherwise, the provisions of Titles 45 and 46 apply to the enforcement of the offenses provided for in this part.

(2) In any prosecution for the offenses provided for and charged under this part, for the purposes of and in addition to the provisions of 46-2-101 and 46-3-110, offenses are deemed to have been committed in any of the following locations:

- (a) the county or judicial district in which the purported loss, damage, or accident occurs;
- (b) the county or judicial district in which the insurance policy provides coverage or, in the case of motor vehicle insurance, where the vehicle is garaged; or
- (c) the county or judicial district in which money or other insurance proceeds were received for the fraudulent act."

Section 7. Section 33-2-116, MCA, is amended to read:

"33-2-116. Issuance or refusal of certificate of authority -- state ownership of certificate. (1) If

upon completion of an insurer's application for a certificate of authority the commissioner finds that the insurer has met the requirements for a certificate of authority under this code, the commissioner shall issue to the insurer a proper certificate of authority. If the commissioner does not find that the insurer is entitled to a certificate of authority, the commissioner shall issue an order refusing to issue a certificate. The commissioner shall act upon an application for a certificate of authority within 180 days after its completion.

(2) The certificate, if issued, must specify the kind or kinds of insurance the insurer is authorized to transact in Montana. At the insurer's request, the commissioner may issue a certificate of authority limited to particular types of insurance or insurance coverages within the scope of a kind of insurance as defined in 33-1-205 through 33-1-212.

(3) Although issued to the insurer, the certificate of authority is at all times the property of the state of Montana. Upon any expiration or termination of the certificate of authority, the insurer shall promptly ~~deliver~~ destroy the certificate of authority to the commissioner."

Section 8. Insurance presumed unobtainable from authorized insurers. At least annually, the commissioner shall make available a list of the kinds of insurance that are presumed to be unobtainable from authorized insurers, known as the approved risk list.

Section 9. Section 33-2-312, MCA, is amended to read:

"33-2-312. Penalty for failure to file statement, pay tax, or pay stamping fee. (1) A surplus lines insurance producer or an insured that independently procured insurance that fails to file the tax and fee statement as required under 33-2-310 or to pay the taxes as required under 33-2-311 is liable for a penalty of up to \$25 for each day of delinquency, commencing 30 calendar days after the due date established by the commissioner by rule. The tax and penalty may be recovered in an action instituted by the commissioner in the name of the state in any court of competent jurisdiction with the attorney general representing the commissioner. The penalty when collected, unless collected by a justice's court, must be paid to the commissioner, forwarded to the state treasurer, and placed to the credit of the general fund. The surplus lines insurance producer's license is also subject to revocation as provided in 33-2-313.

(2) If a surplus lines insurance producer or an insured that independently procured insurance does

not pay the stamping fee provided for in 33-2-321, the commissioner may impose a penalty of 25% of the stamping fee due plus 1.5% a month from the time of delinquency until the stamping fee is paid."

Section 10. Section 33-2-2402, MCA, is amended to read:

"33-2-2402. Definitions. As used in this part, the following definitions apply:

- (1) "Claims processing services" means the administrative services performed in connection with the processing and adjudicating of claims relating to pharmacist services that include either or both of the following:
- (a) receiving payments for pharmacist services; and
 - (b) making payments to pharmacists or pharmacies.
- (2) "Enrollee" means a member, policyholder, subscriber, covered person, beneficiary, dependent, or other individual participating in a health benefit plan.
- (3) "Federally certified health entity" means a 340B covered entity as described in 42 U.S.C. 256b(a)(4).
- (4) "Health benefit plan" means a policy, contract, certificate, or agreement entered into, offered, or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.
- (5) (a) "Health carrier" means an entity that is subject to the insurance laws and regulations of this state or to the jurisdiction of the commissioner and that contracts or offers to contract or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.
- (b) The term includes:
 - (i) self-funded multiple employer welfare arrangements as defined in 33-35-103; and
 - (ii) any other entity providing a plan of health insurance, health benefits, or health care services.
- (6) "Manufacturer" has the meaning provided in 37-7-602.
- (7) "Other prescription drug or device services" means services other than claims processing services that are provided directly or indirectly, whether in connection with or separate from claims processing services, including but not limited to:
- (a) negotiating rebates, discounts, or other financial incentives and arrangements with

manufacturers, wholesale distributors, or other third parties;

- (b) disbursing or distributing rebates;
- (c) managing or participating in incentive programs or arrangements for pharmacist services;
- (d) negotiating or entering into contractual arrangements with pharmacists, pharmacies, or both;
- (e) developing and maintaining formularies;
- (f) designing prescription drug benefit programs;
- (g) advertising or promoting services; or
- (h) administering prior authorization, step therapy, case management, or other utilization review

programs.

(8) "Pharmacist" has the meaning provided in 33-22-170.

(9) "Pharmacist services" means products, goods, and services or any combination of products, goods, and services provided as part of the practice of pharmacy.

(10) "Pharmacy" means an established location, either physical or electronic, that is licensed by the board of pharmacy pursuant to Title 37, chapter 7.

(11) (a) "Pharmacy benefit manager" means a person, including a wholly or partially owned or controlled subsidiary of a pharmacy benefit manager, that provides claims processing services or other prescription drug or device services, or both, to:

- (i) enrollees who are residents of this state, for health benefit plans; or
- (ii) injured workers of workers' compensation insurance carriers.

(b) The term does not include:

- (i) a health care facility as defined in 50-5-101 that is licensed in this state;
- (ii) a health care professional licensed under Title 37;
- (iii) a consultant who provides advice only as to the selection or performance of a pharmacy benefit

manager; or

(iv) a health carrier or workers' compensation insurance carrier to the extent that the carrier performs any claims processing and other prescription drug or device services exclusively for its enrollees or injured workers.

(12) "Pharmacy services administrative organization" means an entity that acts as a contracting

agent or provides contracting and other administrative services to pharmacies to assist them in their interactions with third-party payers and pharmacy benefit managers.

(13) "Plan sponsor" has the meaning provided in 33-10-202.

(14) (a) "Rebates" means all price concessions, however characterized, paid by a manufacturer to a pharmacy benefit manager, including discounts and other remuneration or price concessions, that are based on the actual or estimated utilization of a prescription drug.

(b) The term includes price concessions based on the effectiveness of a prescription drug as in a value-based or performance-based contract.

(15) "Wholesale acquisition cost" has the meaning provided in 42 U.S.C. 1395w-3a.

(16) "Wholesale distributor" or "distributor" has the meaning provided in 37-7-602.

(17) "Workers' compensation insurance carrier" means:

- (a) an insurance company transacting business under compensation plan No. 2; or
- (b) the state fund compensation plan No. 3 under Title 39, chapter 71."

Section 11. Section 33-2-2404, MCA, is amended to read:

"33-2-2404. Pharmacy benefit manager prohibited practices. (1) In any participation contracts between a pharmacy benefit manager and pharmacies, ~~or pharmacists,~~ or pharmacy services administrative organizations providing prescription drug coverage, a pharmacy or pharmacist may not be prohibited, restricted, or penalized in any way from disclosing to any enrollee or injured worker any information the pharmacy or pharmacist considers appropriate regarding:

(a) the decision of utilization reviewers or similar persons to authorize or deny drug coverage or benefits; and

(b) the process that is used to authorize or deny drug coverage or benefits.

(2) (a) A pharmacy benefit manager contract with a participating pharmacy, ~~or pharmacist,~~ or a pharmacy services administrative organization in this state may not prohibit, restrict, or limit disclosure of information to the commissioner when the commissioner is investigating or examining a complaint or conducting a review of a pharmacy benefit manager's compliance with the requirements of this part.

(b) A pharmacy benefit manager may not terminate the contract of or penalize a pharmacy, ~~or~~

pharmacist, or a pharmacy services administrative organization for sharing any portion of the pharmacy benefit manager contract with the commissioner for investigation of a complaint or a question regarding whether the contract complies with this part.

(c) Any examination or review under this section must follow the examination procedures and requirements applicable to insurers under Title 33, chapter 1, part 4, including but not limited to the confidentiality provisions of 33-1-409."

Section 12. Section 33-4-509, MCA, is amended to read:

"33-4-509. Application and policy forms filed with commissioner. All forms of application for insurance and of policies proposed to be used by an insurer must be filed with and approved by the commissioner prior to the issuance, delivery, or use in this state ~~at least 30 days in advance of any use~~. The commissioner shall disapprove any form found by the commissioner to be unlawful, illegible, or misleading. An insurer may not use any form after it has received the commissioner's notice of disapproval setting forth the reasons for disapproval."

Section 13. Service of process. Service of process against a society authorized to do business in this state must be made pursuant to 35-7-113 or in any other manner permitted by law.

Section 14. Section 33-7-531, MCA, is amended to read:

"33-7-531. Foreign or alien society -- admission. (1) A foreign or alien society may not transact business in this state without a license issued by the commissioner of insurance. A foreign or alien society desiring admission to this state shall comply substantially with the requirements and limitations of this chapter applicable to domestic societies. A society may be licensed to transact business in this state upon filing with the commissioner:

- (a) a certified copy of its articles of incorporation;
- (b) a copy of its bylaws, certified by its secretary or corresponding officer;
- ~~(c) a written appointment of the commissioner to be the society's agent, as prescribed in 33-7-123;~~
- ~~(d)~~(c) a statement of its business, under oath of its president and secretary or corresponding officers,

in a form prescribed by the commissioner, verified by an examination made by the supervising insurance official of its home state or other state, district, territory, province, or country satisfactory to the commissioner of this state;

~~(e)~~(d) certification from the proper official of its home state, district, territory, province, or country that the society is legally incorporated and licensed to transact business in that jurisdiction;

~~(f)~~(e) copies of its certificate forms; and

~~(g)~~(f) other information the commissioner considers necessary.

(2) A foreign or alien society applying for authority to transact business in this state must have the qualifications required of domestic societies organized under this chapter."

Section 15. Section 33-10-204, MCA, is amended to read:

"33-10-204. Board of directors -- commissioner approval -- compensation. (1) The board of directors of the association consists of not less than seven or more than nine members serving terms as established in the plan of operation. Two of the members must be appointed from the public at large by the commissioner. The other members of the board must be selected by member insurers subject to the approval of the commissioner. Vacancies on the board must be filled for the remaining period of the term in the manner described in the plan of operation. In approving selections or in appointing members to the board, the commissioner shall consider, among other things, whether all member insurers are fairly represented.

(2) Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors, but members of the board may not otherwise be compensated by the association for their services. However, any designated representatives of members of the board who are not full-time employees of the member insurers that designated them may receive reasonable compensation for their services on the board of directors upon annual approval by the members of the association."

Section 16. Section 33-15-336, MCA, is amended to read:

"33-15-336. Applicability. (1) Other statutes of this state setting simplification standards for language or format do not apply to property and casualty policies.

(2) Sections 33-15-333 through 33-15-340 do not apply to policies in manuscript form or to the following kinds of insurance:

- (a) ocean marine;
- (b) surety and financial institution bonds;
- (c) reinsurance; or
- (d) ~~commercial aviation~~ commercial lines policies, including but not limited to commercial aviation;

or

~~(e) large commercial risks whose aggregate annual premiums for insurance on all risks totals at least \$100,000.~~

(3) A non-English policy is considered in compliance with 33-15-337 if it was translated from an English policy that complies with 33-15-337."

Section 17. Service of process. Service of process against a nonresident person must be made pursuant to 35-7-113 or in any other manner permitted by law.

Section 18. Section 33-17-1101, MCA, is amended to read:

"33-17-1101. Place of business -- display of license -- records. (1) A resident insurance producer shall maintain a place or places of business in this state accessible to the public. A nonresident insurance producer may maintain a place or places of business in this state. An insurance producer's place or places of business must be a place in which transactions are conducted under the insurance producer's license. The address of the primary place of business must appear on the license. This section does not prohibit the maintenance of a place of business in a licensee's place of residence.

(2) The license or, if the insurance producer has more than one place of business, a copy of the license must be conspicuously displayed in a part of the place of business customarily open to the public.

(3) On request, resident and nonresident insurance producers are required to identify themselves and provide their license number to persons with whom they sell, solicit, or negotiate insurance.

~~(3)(4)~~ The insurance producer shall keep at a place of business complete records pertaining to transactions under the license for a period of at least 3 years after completion of the respective transactions,

except that a title insurance producer, as defined in 33-25-105, shall retain records as provided in 33-25-214 and 33-25-216."

Section 19. Section 33-20-606, MCA, is amended to read:

"33-20-606. Variable contracts to meet insurance contract requirements. (1) Except for 33-15-321 through 33-15-329, 33-20-302, and 33-20-307 for variable annuity contracts and 33-20-104, 33-20-110, 33-20-111, 33-20-112, and 33-20-201 through 33-20-213 for variable life insurance policies and as otherwise provided in this part, all pertinent provisions of Title 33 and other laws relating to insurance apply to separate accounts and their related policies and contracts.

(2) Any individual variable life insurance contract or any individual variable annuity contract delivered or issued for delivery in this state must contain grace and reinstatement provisions appropriate to the contract. Any individual variable life insurance contract must contain nonforfeiture provisions appropriate to that contract.

(3) ~~An insurer shall file with the commissioner a copy of a~~ A final prospectus, must be dated and effective, before it ~~an insurer~~ issues or delivers an individual variable life insurance contract or an individual variable annuity contract in this state. The prospectus must be made available to the commissioner on request.

(4) The reserve liability for any variable contract must be established in accordance with actuarial procedures that recognize the variable nature of benefits provided and mortality guarantees."

Section 20. Section 33-20-1304, MCA, is amended to read:

"33-20-1304. Issuance of license. (1) The commissioner may issue a license to the applicant if the commissioner determines that the applicant:

- (a) has satisfied all of the requirements for the license for which an application is made;
- (b) has not engaged in conduct that would authorize the commissioner to refuse to issue a license under this part; and
- (c) is financially responsible and has a good business reputation.

~~(2) The commissioner may issue a license to a nonresident applicant only if the nonresident applicant files with the commissioner in writing an appointment of the commissioner to be the agent of the applicant upon~~

~~whom all legal process in any action or proceeding against the applicant may be served. In the appointment, the applicant shall agree that any lawful process against the applicant that is served upon the commissioner is of the same legal force and validity as if served upon the applicant and that the authority will continue in force as long as any liability remains outstanding in this state. An appointment under this subsection becomes effective on the date that the commissioner issues the license to the applicant.~~

~~(3)(2)~~ If the commissioner denies an application, the commissioner shall inform the applicant and state the grounds for the denial.

~~(4)(3)~~ An individual may act as a viatical settlement provider or viatical settlement broker under the authority of the license of a firm or of a corporate viatical settlement provider whether or not the individual holds a license as a viatical settlement provider if:

(a) the individual is a member or employee of the firm or is an employee, officer, or director of the corporation; and

(b) the individual is designated by the firm or corporation on its license application or on a form that amends or supplements the application as being authorized to act as a viatical settlement provider under the authority of the license."

Section 21. Section 33-20-1316, MCA, is amended to read:

"33-20-1316. Service of process. (1) For viatical settlement providers, the provisions of Title 33, chapter 1, part 6, apply.

(2) For viatical settlement brokers, ~~the provisions of 33-17-405 apply~~ service of process must be made pursuant to 35-7-113 or in any other manner permitted by law."

Section 22. Section 33-22-156, MCA, is amended to read:

"33-22-156. Health insurance rates -- filing required -- use. (1) Each health insurance issuer that issues, delivers, or renews individual or small employer group health insurance coverage in the individual or small employer group market shall, at least 60 days before the rate goes into effect, file with the commissioner its rates, fees, dues, and other charges for each product form intended for use in Montana, together with sufficient information to support the premium to be charged as described in 33-22-156 through 33-22-159. This

filing may be made simultaneously with a notice of premium increase to policyholders and certificate holders required by 33-22-107.

(2) A health insurance issuer may submit a single combined justification for rate increases subject to review affecting multiple products if the claims experience of all products has been aggregated to calculate the rate increases and the rate increases are the same for all products. Rate increases are determined by combining the total amount of increases taken on a single product form or market segment, if the rate increase is the same for all products, over a 12-month period. A market segment means the individual or small group market.

(3) The commissioner may waive the 60-day filing requirement under subsection (1) if the rate increase is implemented pursuant to 33-22-107(1)(b). However, the rates and justifications for the rate increase still must be filed.

(4) The health insurance issuer shall submit a new filing to reflect any material change to the previous rate filing. For all other changes, the insurer shall submit an amendment to a previous rate filing. The insurer may file an actuarial trend to phase in rate increases over a 12-month period. The insurer may file amendments to that trend within the 12-month period.

(5) The filing of rates for health plans must include:

(a) the product form number or numbers and approval date of the product form or forms to which the rate applies;

(b) a statement of actuarial justification; and

(c) information sufficient to support the rate as described in 33-22-157.

(6) The commissioner shall prescribe the form and content of the information required under this section.

(7) A rate filing required under this section must be submitted by a qualified actuary representing the health insurance issuer. The qualified actuary shall certify in a form prescribed by the commissioner that, to the best of the actuary's knowledge and belief, the rates are not excessive, inadequate, unjustified, or unfairly discriminatory, as described in 33-22-157, and comply with the applicable provisions of Title 33 and rules adopted pursuant to Title 33.

(8) The rate filing must be delivered by the national association of insurance commissioners'

system for electronic rate and form filing.

(9) ~~An~~ Subject to 33-22-157(4), an insurer may use a rate filing under this section 60 days after the date of filing with the commissioner unless the health insurance issuer fails to provide the minimum documentation required in 33-22-157.

(10) Sections 33-22-156 through 33-22-159 do not apply to coverage consisting solely of excepted benefits as defined in 33-22-140."

Section 23. Section 33-22-170, MCA, is amended to read:

"33-22-170. Definitions. As used in 33-22-170 through 33-22-177 and 33-22-180, the following definitions apply:

(1) "Contract pharmacy" means a pharmacy operating under contract with a federally certified health entity to provide dispensing services to the federally certified health entity.

(2) "Federally certified health entity" means a 340B covered entity as described in 42 U.S.C. 256b(a)(4).

(3) "Maximum allowable cost list" means the list of drugs used by a pharmacy benefit manager that sets the maximum cost on which reimbursement to a network pharmacy or pharmacist is based.

(4) "Pharmacist" means a person licensed by the state to engage in the practice of pharmacy pursuant to Title 37, chapter 7.

(5) "Pharmacy" means an established location, either physical or electronic, that is licensed by the board of pharmacy pursuant to Title 37, chapter 7, and that has entered into a network contract with a pharmacy benefit manager, health insurance issuer, or plan sponsor.

(6) "Pharmacy benefit manager" means a person who contracts with pharmacies on behalf of a health insurance issuer, third-party administrator, or plan sponsor to process claims for prescription drugs, provide retail network management for pharmacies or pharmacists, pay pharmacies or pharmacists for prescription drugs, or provide other prescription drug or device services.

(7) "Pharmacy performance measurement entity" means:

(a) the electronic quality improvement platform for plans and pharmacies; or

(b) an entity approved by the board of pharmacy provided for in 2-15-1733 as a nationally

recognized and unbiased entity that assists pharmacies in improving performance measures.

(8) "Pharmacy services administrative organization" means an entity that acts as a contracting agent or provides contracting and other administrative services to pharmacies to assist them in their interactions with third-party payers and pharmacy benefit managers.

~~(8)~~(9) "Prescription drug" means any drug that is required by federal law or regulation to be dispensed only by a prescription subject to section 353(b) of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. 301 et seq.

~~(9)~~(10) "Prescription drug order" has the meaning provided in 37-7-101.

~~(10)~~(11) "Reference pricing" means a calculation for the price of a pharmaceutical that uses the most current nationally recognized reference price or amount to set the reimbursement for prescription drugs and other products, supplies, and services covered by a network contract between a plan sponsor, health insurance issuer, or pharmacy benefit manager and a pharmacy or pharmacist."

Section 24. Section 33-22-172, MCA, is amended to read:

"33-22-172. Maximum allowable cost or reference price list -- price formulation, updating, and disclosure -- exceptions. (1) At the time of entering into a contract with a pharmacy or a pharmacy services administrative organization and subsequently upon request, a plan sponsor, health insurance issuer, or pharmacy benefit manager shall provide the pharmacy or pharmacy services administrative organization with the sources used to determine the pricing for the maximum allowable cost list or the reference used for reference pricing.

(2) If using a maximum allowable cost list, a plan sponsor, health insurance issuer, or pharmacy benefit manager shall:

(a) review and update the price information for each drug on the maximum allowable cost list at least once every 10 calendar days to reflect any modification of pricing;

(b) establish a process for eliminating products from the maximum allowable cost list or modifying the prices in the maximum allowable cost list in a timely manner to remain consistent with pricing changes and product availability in the marketplace; and

(c) provide a process for each pharmacy to readily access the maximum allowable cost list specific

to the pharmacy in a searchable and usable format.

(3) If using reference pricing, a plan sponsor, health insurance issuer, or pharmacy benefit manager shall:

- (a) review and update no less than every 10 business days the price information for each drug, product, supply, or service for which reference pricing is used; and
- (b) provide a process for each pharmacy to readily access the reference pricing specific to the plan sponsor or the health insurance issuer's plan.

(4) A plan sponsor, health insurance issuer, or pharmacy benefit manager may not:

- (a) prohibit a pharmacist from discussing reimbursement criteria with a covered person;
- (b) penalize a pharmacy or a pharmacist for disclosing the information described in subsection (4)(a) to a covered person or for selling a more affordable alternative to a covered person; or
- (c) require a pharmacy to charge or collect a copayment from a covered person that exceeds the total charges submitted by the network pharmacy."

Section 25. Section 33-22-173, MCA, is amended to read:

"33-22-173. Maximum allowable cost -- appeals process. (1) In contracting with a pharmacy, a pharmacy services administrative organization, a plan sponsor or pharmacy benefit manager shall:

- (a) provide a procedure by which a pharmacy or a pharmacy services administrative organization may appeal the price of a drug or drugs on the maximum allowable cost list;
 - (b) provide a telephone number at which a network pharmacy may contact the pharmacy benefit manager to discuss the status of the pharmacy's appeal; and
 - (c) respond to an appeal no later than 10 calendar days after the date the appeal is made.
- (2) If the final determination is a denial of the pharmacy's or the pharmacy services administrative organization's appeal, the pharmacy benefit manager shall state the reason for the denial and provide the national drug code of an equivalent drug that is available for purchase by pharmacies in this state from national or regional wholesalers at a price that is equal to or less than the maximum allowable cost for that drug.
- (3) If a pharmacy's or a pharmacy services administrative organization's appeal is determined to be valid by the pharmacy benefit manager, the pharmacy benefit manager shall:

- (a) make an adjustment in the drug price effective on the date the appeal is resolved;
- (b) make the adjustment applicable to all similarly situated network pharmacy providers as determined by the plan sponsor or the pharmacy benefit manager, as appropriate; and
- (c) permit the appealing pharmacy to reverse and rebill the claim in question, using the dates of the original claim or claims.
- (4) A pharmacy benefit manager shall make price adjustments to all similarly situated pharmacies within 3 days.
- (5) A pharmacy or a pharmacy services administrative organization shall file its appeal within 10 calendar days of its submission of the initial claim for reimbursement from the time of denial by the pharmacy benefit manager."

Section 26. Section 33-22-177, MCA, is amended to read:

"33-22-177. Rights of pharmacies. (1) A pharmacy benefit manager or third-party payer may not prohibit a pharmacist or pharmacy from:

- (a) participating in a class-action lawsuit;
- (b) disclosing to the plan sponsor or to the patient information regarding the adjudicated reimbursement paid to the pharmacy if the pharmacist or pharmacy complies with the requirements of the federal Health Insurance Portability and Accountability Act of 1996, 29 U.S.C. 1181 et seq.;
- (c) providing relevant information to a patient about the patient's prescription drug order, including but not limited to the cost and clinical efficacy of a more affordable alternative drug if one is available;
- (d) mailing or delivering a prescription drug to a patient as an ancillary service of a pharmacy if the practice is not prohibited under Title 37, chapter 7; or
- (e) charging a shipping and handling fee to a patient who has asked that a prescription drug be mailed or delivered if the practice is not prohibited under Title 37, chapter 7.
- (2) A pharmacy benefit manager or third-party payer may not require pharmacy accreditation standards or recertification requirements inconsistent with, more stringent than, or in addition to federal and state requirements for licensure as a pharmacy in this state.
- (3) A pharmacist or pharmacy that belongs to a pharmacy services administrative organization

may receive a copy of a contract the pharmacy services administrative organization entered into with a pharmacy benefit manager or third-party payer on the pharmacy's or pharmacist's behalf.

(4) A pharmacy benefit manager or third-party payer shall provide a pharmacy or pharmacist with the processor control number, bank identification number, and group number for each pharmacy network established or administered by a pharmacy benefit manager or third-party payer to enable the pharmacy to make an informed contracting decision.

(5) (a) A pharmacy benefit manager shall:

(i) offer a pharmacy or a pharmacy services administrative organization an opportunity to renew an existing contract every 3 years, at a minimum; and

(ii) allow a pharmacy or a pharmacy services administrative organization to terminate a contract upon a 90-day notice to the pharmacy benefit manager.

(b) An addendum or amendment to an existing contract between a pharmacy benefit manager and a pharmacy or a pharmacy services administrative organization is effective only upon signing of the addendum or amendment by both parties.

(6) A pharmacy or a pharmacy services administrative organization has a private right of action to enforce provisions of 33-22-175 through 33-22-177."

Section 27. Section 33-22-1128, MCA, is amended to read:

"33-22-1128. Insurance producer training requirements. (1) An individual may not sell, solicit, or negotiate long-term care insurance unless the individual is licensed as an insurance producer for disability or life insurance, has completed a one-time training course ~~on or before July 1, 2008~~, and completes ongoing training within every 24-month period ~~following July 1, 2008~~.

(2) The training requirements of this section may be approved as continuing education courses under Title 33, chapter 17, part 12.

(3) The one-time training course required by this section may not be less than 8 hours, and the ongoing training required by this section may not be less than 4 hours for each 24-month period.

(4) (a) The training must consist of topics related to long-term care insurance, long-term care services, and, if applicable, qualified state long-term care insurance partnership programs.

- (b) The training must address but is not limited to:
- (i) state and federal regulations and requirements and the relationship between qualified state long-term care insurance partnership programs and other public and private coverage of long-term care services, including medicaid;
 - (ii) available long-term care services and providers;
 - (iii) changes or improvements in long-term care services or providers;
 - (iv) alternatives to the purchase of private long-term care insurance;
 - (v) the effect of inflation on benefits and the importance of inflation protection; and
 - (vi) consumer suitability standards and guidelines.
- (5) The training required by this section may not include training that is specific to the insurer or a company product or that includes any sales or marketing information, materials, or training, other than those required by state or federal law.
- (6) (a) An insurer subject to this section shall obtain verification that an insurance producer acting on the insurer's behalf receives the training required by this section before the insurance producer is permitted to sell, solicit, or negotiate the insurer's long-term care insurance products.
- (b) The insurer shall maintain records subject to this state's record retention requirements and make the verification of the insurance producer's compliance with training requirements available to the commissioner upon request.
- (7) (a) An insurer subject to this section shall maintain records with respect to the training of its insurance producers concerning the distribution of its policies that will allow the commissioner to provide assurance to the department of public health and human services that insurance producers have received the required training and that the insurance producers have demonstrated an understanding of the insurer's policies and the relationship of the policies to public and private coverage of long-term care, including medicaid, in this state.
- (b) The records must be maintained in accordance with this state's record retention requirements and must be made available to the commissioner upon request.
- (8) The satisfaction of the training requirements required by this section in any state must be considered to satisfy the training requirements in this state."

Section 28. Section 33-22-1316, MCA, is amended to read:

"33-22-1316. Administration of reinsurance payments. (1) Claims that are incurred during a benefit year and are submitted for reimbursement in the following benefit year by the date established ~~by the board~~ by the board in the plan of operation will be allocated to the benefit year in which they are incurred. ~~Claims submitted after the date established by the board following the benefit year in which they were incurred will be allocated to the next benefit year in accordance with the board's operating rules, policies, and procedures. Any claims from the preceding benefit year not submitted for reimbursement by the date established in the plan of operation may not be reimbursed.~~

(2) If funds accumulated in the reinsurance program account in the state special revenue fund with respect to a benefit year are expected to be insufficient to pay all program expenses, claims for reimbursement, and other disbursements allocable to that benefit year, all claims for reimbursement allocable to that benefit year must be reduced proportionately to the extent necessary to prevent a deficiency in the funds for that benefit year. Any reduction in claims for reimbursement with respect to a benefit year must apply to all claims that are allocated to that benefit year without regard to when those claims were submitted for reimbursement, and any reduction must be applied to each claim in the same proportion.

(3) If funds accumulated in the reinsurance program account in the state special revenue fund exceed the actual claims for reimbursement and program expenses of the association in a given benefit year, ~~the board~~ board shall use ~~such the~~ excess funds to pay reinsurance claims in successive benefit years ~~and may recommend to the commissioner a reduction in the assessment amount for the following year and may recommend to the commissioner a reduction in the assessment amount for the following year.~~

(4) For each applicable benefit year, ~~the board~~ board shall notify eligible health insurers of reinsurance payments to be made for the applicable benefit year by the date established ~~by the board~~ in the plan of operation in the year following the applicable benefit year.

(5) By December 31 of the year following the applicable benefit year, ~~the board~~ board shall disburse all applicable reinsurance payments payable to an eligible health insurer."

Section 29. Section 33-23-310, MCA, is amended to read:

"33-23-310. Medical malpractice insurance report by insurer. (1) ~~Each~~ If requested in writing by the commissioner, each insurer engaged in issuing medical malpractice professional liability insurance in this state shall, within 60 days, provide a report to the commissioner containing the following categories of information, as directed by the commissioner, for one or more professions provided in subsection (2)(b) include ~~the following, by profession and based upon the insurer's experience in this state, in its annual statement to the commissioner of insurance:~~

- (a) the number of medical malpractice insureds as of December 31 of the preceding calendar year;
 - (b) the amount of direct premiums written and direct premiums paid for medical malpractice insurance during the preceding calendar year;
 - (c) the number of medical malpractice claims made against its insureds during the preceding calendar year;
 - (d) the number of medical malpractice claims that were closed and that had a direct loss paid during the preceding calendar year, together with the total amount of direct losses paid for all closed claims for that year;
 - (e) the number of medical malpractice claims that were still open and had no direct losses paid as of December 31 of the preceding calendar year;
 - (f) the number of claims filed against its insureds in state and federal courts during the preceding calendar year, including the number of claims that were closed:
 - (i) without settlement during the preceding calendar year;
 - (ii) with a settlement during the preceding calendar year and the total amount paid for those claims;
 - (iii) during the preceding calendar year and that went to trial and the number that resulted in a judgment or verdict for the plaintiff, the number that resulted in a judgment or verdict for the insured, and the number that resulted in some other judgment or verdict;
 - (g) the total direct losses paid for claims against its medical malpractice insureds that went to trial and were closed during the preceding year; and
 - (h) other information and statistics that the commissioner of insurance requires.
- (2) For purposes of this section:

- (a) "insurer" has the meaning provided in 33-1-201; and
- (b) "profession" includes the categories of physician, osteopath, podiatrist, dentist, optometrist, registered nurse, licensed practical nurse, or health care facility as defined in 50-5-101."

Section 30. Section 33-25-105, MCA, is amended to read:

"33-25-105. Definitions. As used in this chapter, the following definitions apply:

- (1) "Abstract" means a written representation, provided pursuant to a contract and expected to be relied upon by the person who has contracted for the receipt of that representation, listing all recorded conveyances, instruments, or documents which, under the laws of this state, impart constructive notice regarding the chain of title to real property described in the abstract. Abstract includes "abstract of title".
- (2) "Applicant" means a person, whether or not a prospective insured, who applies to a title insurer or title insurance producer for a title insurance policy, but does not include a title insurance producer.
- (3) "Approved attorney" means an attorney authorized to practice law in this state, except an agent or employee of a title insurer, whose certification as to the status of the title to real property a title insurer is willing to accept as the basis for issuance of a title insurance policy.
- (4) "Associate" means a:
 - (a) corporation, partnership, or other business entity organized for profit, of which a producer of title business is a director, officer, partner, employee, or owner of 5% or more of its equity or capital;
 - (b) franchisor or franchisee of a producer of title business;
 - (c) spouse, parent, or child of a producer of title business;
 - (d) corporation, partnership, or other business entity that controls, is controlled by, or is under common control with a producer of title business; or
 - (e) person with whom a producer of title business or an associate has an agreement, arrangement, understanding, or course of conduct having the purpose or substantial effect of evading the provisions of this title.
- (5) "Controlled business" means that portion of the business of title insurance in this state of a title insurer or title insurance producer that is referred to it by a producer or associate having a financial interest in the title insurer or title insurance producer.

(6) "Financial interest" means a legal or beneficial interest that entitles the holder, directly or indirectly, to 1% or more of the net profits or net worth of the entity in which the interest is held.

(7) "Preliminary report" means an offer to issue a title insurance policy subject to any exceptions stated in the report or other matters that may be incorporated by reference therein. Preliminary report includes a commitment or binder.

(8) "Producer of title business" or "producer" means a person, corporation, partnership, or other business entity, including an officer, director, or owner of 5% or more of the equity or capital thereof, engaged in this state in the trade, business, occupation, or profession of:

- (a) buying or selling interests in real property;
- (b) making loans secured by interests in real property; or
- (c) acting as broker, insurance producer, or representative of a person described in subsection (8)(a) or (8)(b).

(9) "Rate" means fees for:

- (a) issuing a title insurance policy, including any service charge or fee for the issuance;
- (b) abstracting, searching, and examining title to real property when prepared or issued in contemplation of or in conjunction with the issuance of a title insurance policy; and
- (c) preparing or issuing preliminary reports, commitments, binders, or similar products prepared or issued in contemplation of or in conjunction with the issuance of a title insurance policy.

(10) "Refer" means to direct, cause to be directed, or exercise an influence over the direction of title insurance business, whether or not the consent or approval of another person is sought or obtained with respect to the referral.

(11) "Title guarantee" means a contract by which, subject to its stated terms and conditions, a title insurer guarantees the assured against loss sustained by reason of the incorrectness of assurances set forth in the title guarantee with respect to the stated property. The term includes a trustee's sale guarantee, litigation guarantee, lot book guarantee, subdivision guarantee, recorded documents guarantee, or other form of guarantee filed with and approved by the commissioner.

~~(11)~~(12) "Title insurance business" means:

- (a) issuing or offering to issue a title insurance policy as an insurer;

(b) transacting or proposing to transact any of the following as a title insurer or title insurance producer, in contemplation of or in conjunction with the issuance of a title insurance policy:

- (i) soliciting or negotiating the issuance of a title insurance policy;
- (ii) guaranteeing, warranting, or otherwise insuring the correctness of title searches;
- (iii) handling escrows, settlements, or closings;
- (iv) executing title insurance policies, reports, commitments, binders, and endorsements;
- (v) effecting contracts of reinsurance; or
- (vi) abstracting, searching, or examining titles;

(c) transacting, as a title insurer or insurance producer, matters subsequent to the issuance of a title insurance policy and arising out of the policy; or

(d) doing or proposing to do business that, in substance, is equivalent to any of the activities described in subsections ~~(11)(a) through (11)(c)~~ (12)(a) through (12)(c) in a manner designed to evade the provisions of this title.

~~(12)~~(13) "Title insurance policy" means a contract by which, subject to its stated terms and conditions, a title insurer insures or indemnifies the insured against loss or damage sustained by reason of:

- (a) defects in or liens or encumbrances on the title to the stated property;
- (b) unmarketability of the title to the stated property; or
- (c) invalidity or unenforceability of liens or encumbrances on the stated property.

~~(13)~~(14) (a) "Title insurance producer" means a person who holds a valid title insurance producer's license and is authorized in writing by a title insurer to:

- (i) solicit title insurance business;
 - (ii) collect rates;
 - (iii) determine insurability in accordance with underwriting rules and standards of the insurer; or
 - (iv) issue policies of the title insurer.
- (b) Title insurance producer does not include an approved attorney.

~~(14)~~(15) "Title insurer" means an insurer formed and authorized under the laws of this state to transact the business of title insurance in this state or a foreign or alien insurer so authorized.

~~(15)~~(16) "Title plant" means a set of privately maintained records in which entries have been made of

documents imparting constructive notice, under the law, of matters affecting title to real property, an interest therein, or an encumbrance thereon, that have been filed or recorded in the jurisdiction for which the title plant is maintained and from which the ownership of real property within the jurisdiction can be ascertained and liens, encumbrances, defects, and clouds on title to the real property can be determined."

Section 31. Section 33-25-301, MCA, is amended to read:

"33-25-301. Refusal, suspension, or revocation of title insurance producer's license. (1) In addition to the causes provided in 33-17-1001, the commissioner may refuse to license an applicant or renew the license of a person as a title insurance producer or may suspend or revoke a title insurance producer's license or may fine a title insurance producer or applicant, after notice and opportunity for a hearing, if the commissioner finds that the license applicant or licensee has:

- (a) made a material misstatement in an application for a title insurance producer license;
- (b) commingled funds belonging to applicants, escrow participants, or others;
- (c) intentionally misrepresented the terms of a title insurance policy to an applicant or policyholder or has misrepresented material facts to, concealed material facts from, or made false statements to a party to an escrow, settlement, or closing transaction;
- (d) in conducting affairs as a title insurance producer, used coercive practices or demonstrated financial irresponsibility;
- (e) aided, abetted, or assisted another person in violating the provisions of this title or a rule adopted by the commissioner.

(2) The commissioner may impose any other appropriate penalty provided for in this title.

(3) The commissioner may issue an order requiring restitution to injured parties and reimbursement of the commissioner's reasonable costs of bringing an administrative action pursuant to this section.

~~(3)~~(4) The commissioner may refuse, suspend, or revoke the license of a person licensed as a title insurance producer for the actions described in subsection (1) committed by any individual designated in the license."

Section 32. Section 33-31-201, MCA, is amended to read:

"33-31-201. Establishment of health maintenance organizations. (1) Notwithstanding any law of this state to the contrary, a person may apply to the commissioner for and obtain a certificate of authority to establish and operate a health maintenance organization in compliance with this chapter. A person may not establish or operate a health maintenance organization in this state except as authorized by a subsisting certificate of authority issued to it by the commissioner. A foreign person may qualify for a certificate of authority if it first registers with the secretary of state to transact business in this state as a foreign corporation under 35-14-1502.

(2) Each application of a health maintenance organization, whether separately licensed or not, for a certificate of authority must:

- (a) be verified by an officer or authorized representative of the applicant;
- (b) be in a form prescribed by the commissioner;
- (c) contain:
 - (i) the applicant's name;
 - (ii) the location of the applicant's home office or principal office in the United States, if a foreign person;
 - (iii) the date of organization or incorporation;
 - (iv) the form of organization, including whether the providers affiliated with the health maintenance organization will be salaried employees or group or individual contractors;
 - (v) the state or country of domicile; and
 - (vi) any additional information that the commissioner may reasonably require; and
- (d) set forth the following information or be accompanied by the following documents, as applicable:
 - (i) a copy of the applicant's organizational documents, such as its corporate charters or articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments to those documents, certified by the public officer with whom the originals were filed in the state or country of domicile;
 - (ii) a copy of the bylaws, rules, and regulations, or similar document, if any, regulating the conduct

of the applicant's internal affairs, certified by its secretary or other officer having custody of the documents;

(iii) a list of the names, addresses, and official positions of the persons responsible for the conduct of the applicant's affairs, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers in the case of a corporation, and the partners or members in the case of a partnership or association;

(iv) a copy of any contract made or to be made between:

(A) any provider and the applicant; or

(B) any person listed in subsection (2)(d)(iii) and the applicant. The applicant may file a list of providers executing a standard contract and a copy of the contract instead of copies of each executed contract.

(v) the extent to which any of the following will be included in provider contracts and the form of any provisions that:

(A) limit a provider's ability to seek reimbursement for basic health care services or health care services from an enrollee;

(B) permit or require a provider to assume a financial risk in the health maintenance organization, including any provisions for assessing the provider, adjusting capitation or fee-for-service rates, or sharing in the earnings or losses; and

(C) govern amending or terminating an agreement with a provider;

(vi) a financial statement showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent certified financial statement satisfies this requirement unless the commissioner directs that additional or more recent financial information is required for the proper administration of this chapter.

(vii) a description of the proposed method of marketing, a financial plan that includes a projection of operating results anticipated until the organization has had net income for at least 1 year, and a statement as to the sources of working capital as well as any other source of funding;

~~(viii) a power of attorney executed by the applicant, on a form prescribed by the commissioner, appointing the commissioner, the commissioner's successors in office, and the commissioner's authorized deputies as the applicant's attorney to receive service of legal process issued against it in this state;~~

~~(ix)~~(viii) a statement reasonably describing the geographic service area or areas to be served, by

county, including:

(A) a chart showing the number of primary and specialty care providers, with locations and service areas by county;

(B) the method of handling emergency care, with the location of each emergency care facility; and

(C) the method of handling out-of-area services;

~~(x)(ix)~~ a description of the way in which the health maintenance organization provides services to enrollees in each geographic service area, including the extent to which a provider under contract with the health maintenance organization provides primary care to those enrollees;

~~(xi)(x)~~ a description of the complaint procedures to be used as required under 33-31-303;

~~(xii)(xi)~~ a description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation under 33-31-222;

~~(xiii)(xii)~~ a summary of the way in which administrative services will be provided, including the size and qualifications of the administrative staff and the projected cost of administration in relation to premium income. If the health maintenance organization delegates management authority for a major corporate function to a person outside the organization, the health maintenance organization shall include a copy of the contract in its application for a certificate of authority. Contracts for delegated management authority must be filed with the commissioner in accordance with the filing provisions of 33-31-301(2). However, this subsection ~~(2)(d)(xii)~~ does not deprive the health maintenance organization of its right to confidentiality of any proprietary information, and the commissioner may not disclose that proprietary information to any other person. All contracts must include:

(A) the services to be provided;

(B) the standards of performance for the manager;

(C) the method of payment, including any provisions for the administrator to participate in the profits or losses of the plan;

(D) the duration of the contract; and

(E) any provisions for modifying, terminating, or renewing the contract.

~~(xiv)(xiii)~~ a summary of all financial guaranties by providers, sponsors, affiliates, or parents within a holding company system or any other guaranties that are intended to ensure the financial success of the plan, including hold harmless agreements by providers, insolvency insurance, reinsurance, or other guaranties;

~~(xv)~~(xiv) a summary of benefits to be offered enrollees, including any limitations and exclusions and the renewability of all contracts to be written;

~~(xvi)~~(xv) evidence that it can meet the requirement of 33-31-216(10); and

~~(xvii)~~(xvi) any other information that the commissioner may reasonably require to make the determinations required in 33-31-202.

(3) Each health maintenance organization shall file each substantial change, alteration, or amendment to the information submitted under subsection (2) with the commissioner at least 30 days prior to its effective date, including changes in articles of incorporation and bylaws, organization type, geographic service area, provider contracts, provider availability, plan administration, financial projections and guaranties, and any other change that might affect the financial solvency of the plan. The commissioner may, after notice and hearing, disapprove any proposed change, alteration, or amendment to the business plan. The commissioner may adopt reasonable rules exempting from the filing requirements of this subsection those items that the commissioner considers unnecessary.

(4) An applicant or a health maintenance organization holding a certificate of authority shall file with the commissioner all contracts of reinsurance and any modifications to the contracts. An agreement between a health maintenance organization and an insurer is subject to Title 33, chapter 2, part 12. A reinsurance agreement must remain in full force and effect for at least 90 days following written notice of cancellation by either party by certified mail to the commissioner.

(5) Each health maintenance organization shall maintain at its administrative office and make available to the commissioner upon request executed copies of all provider contracts.

(6) The commissioner may adopt reasonable rules exempting an insurer or health service corporation operating a health maintenance organization as a plan from the filing requirements of this section if information requested in the application has been submitted to the commissioner under other laws and rules administered by the commissioner.

(7) (a) The commissioner may waive the requirements of this section for a PACE organization that has entered into a PACE program agreement pursuant to 42 U.S.C. 1396u-4.

(b) A request for waiver must be submitted in a form prescribed by the commissioner. The waiver application must be filed and approved annually. The annual renewal process must be completed by June 30 of

each year.

(c) The factors that the commissioner may take into account when granting a waiver include but are not limited to the financial condition of the PACE organization, any consumer complaints against the PACE organization, and the length of time the PACE organization has been in business.

(d) The PACE organization shall submit an audited financial statement for the organization as a whole and a financial statement for the PACE program specifically with the initial waiver application and annually on June 30. The commissioner may request additional information necessary to evaluate the waiver request.

(e) The waiver automatically expires if the certification of the PACE organization by the centers for medicare and medicaid services or the department of public health and human services expires or is terminated.

(f) The PACE organization shall notify the commissioner within 30 days if the centers for medicare and medicaid services takes adverse action or issues any warnings regarding the continuation of the PACE organization.

(8) (a) (i) The commissioner may waive the requirements of this section for an accountable care organization. Upon establishment of a medicare shared savings program pursuant to 42 U.S.C. 1395jjj, an accountable care organization shall demonstrate compliance with the program requirements in a manner determined by the commissioner.

(ii) The commissioner shall follow the medicare shared savings program structure in developing compliance criteria needed for obtaining a waiver.

(b) A request for waiver must be submitted in a form prescribed by the commissioner. The waiver application must be filed and approved every 3 years. The renewal process must be completed by June 30 of every third year.

(c) The factors that the commissioner may take into account when granting a waiver include but are not limited to the financial condition of the accountable care organization, any consumer complaints against the organization, and the length of time the organization has been in business.

(d) The accountable care organization shall submit an audited financial statement for the organization as a whole and a financial statement for the accountable care organization program specifically

with the initial waiver application and annually by June 30. The commissioner may request additional information necessary to evaluate the waiver request.

(e) The waiver automatically expires if certification of the accountable care organization under the medicare shared savings program or the department of public health and human services expires or is terminated."

Section 33. Section 33-32-215, MCA, is amended to read:

"33-32-215. Emergency services. (1) When conducting a utilization review or making a benefit determination for emergency services, a health insurance issuer that provides benefits for services in an emergency department of a hospital shall follow the provisions of this section.

(2) A health insurance issuer shall cover emergency services that screen and stabilize a covered person:

(a) without the need for prior authorization of the emergency services if a prudent lay person would have reasonably believed that an emergency medical condition existed even if the emergency services are provided on an out-of-network basis;

(b) without regard to whether the health care provider furnishing the services is a participating provider with respect to the emergency services;

(c) if the emergency services are provided out-of-network, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from network providers;

(d) if the emergency services are provided out-of-network, by complying with the cost-sharing requirements in subsection (4); and

(e) without regard to any other term or condition of coverage, other than:

(i) the exclusion of or coordination of benefits;

(ii) an affiliation or waiting period as permitted under 42 U.S.C. 300gg-19a; or

(iii) cost-sharing, as provided in subsection (4)(a) or (4)(b), as applicable.

(3) For in-network emergency services, coverage of emergency services is subject to applicable copayments, coinsurance, and deductibles.

(4) (a) ~~Except as provided in subsection (4)(b), for out-of-network emergency services, any cost-sharing requirement imposed with respect to a covered person may not exceed the cost-sharing requirement for a covered person if the services were provided in-network.~~ Only in-network cost sharing amounts may be imposed on out-of-network emergency services.

~~(b) A covered person may be required to pay, in addition to the in-network cost-sharing expenses, the excess amount the out-of-network provider charges that exceeds the amount the health insurance issuer is required to pay under this subsection (4).~~

~~(e)(b)~~ A health insurance issuer complies with the requirements of this section by paying for emergency services provided by an out-of-network provider in an amount not less than the greatest of the following and taking into account exceptions in subsections ~~(4)(d)~~ (4)(c) and ~~(4)(e)~~ (4)(d):

(i) the amount negotiated with in-network providers for emergency services, excluding any in-network cost-sharing imposed with respect to the covered person;

(ii) the amount of the emergency service calculated using the same method the plan uses to determine payments for out-of-network services but using the in-network cost-sharing provisions instead of the out-of-network cost-sharing provisions; or

(iii) the amount that would be paid under medicare for the emergency services, excluding any in-network cost-sharing requirements.

~~(d)(c)~~ For capitated or other health plans that do not have a negotiated charge for each service for in-network providers, subsection ~~(4)(e)(i)~~ (4)(b)(i) does not apply.

~~(e)(d)~~ If a health plan has more than one negotiated amount for in-network providers for a particular emergency service, the amount in subsection ~~(4)(e)(i)~~ (4)(b)(i) is the median of those negotiated amounts.

~~(5) Only in-network cost-sharing amounts may be imposed on out-of-network emergency services.~~

~~(6)(5)~~ A health insurance issuer shall allow a covered person, the person's authorized representative, and the person's health care provider at least 24 hours following an emergency admission or the provision of emergency services to notify the health insurance issuer of the admission or provision of emergency services. If the admission or the emergency services occur on a holiday or weekend, a health insurance issuer shall allow notification no later than by the next business day following the admission or provision of emergency services.

~~(7)(6)~~ If prior authorization is required for a postevaluation or poststabilization services review, a

health insurance issuer shall provide access to a designated representative 24 hours a day, 7 days a week, to facilitate the review.

~~(8) A health insurance issuer may not impose prior authorization or step therapy requirements for an oral therapy prescription used to treat opioid use disorder."~~

Section 34. Section 33-33-102, MCA, is amended to read:

"33-33-102. Scope -- rulemaking. (1) This chapter applies to property and casualty insurers seeking utilization review opinions and to utilization review organizations that provide opinions with respect to property and casualty insurance contracts issued in this state.

(2) The commissioner may adopt rules to implement the provisions of this chapter, including but not limited to ~~registration procedures and~~ medical privacy requirements."

Section 35. Section 33-33-201, MCA, is amended to read:

"33-33-201. Standards for utilization review organizations. (1) A utilization review organization that conducts utilization reviews in this state for property and casualty insurers shall meet the standards set forth in this part ~~register with the commissioner prior to performing utilization reviews. The commissioner shall place a utilization review organization on the register when the utilization review organization provides information that establishes that the utilization review organization meets the standards set forth in this section. The commissioner shall remove from the register a utilization review organization that fails to meet the standards set forth in this section.~~

(2) Utilization review organizations may use only licensed or certified health care professionals to conduct utilization reviews.

(3) Utilization reviews must be conducted by health care professionals who are licensed or certified in the same specialty as the provider whose treatment is being received by the insured or by a health care professional who is qualified to render the treatment being reviewed.

(4) Utilization review organizations shall comply with all applicable state or federal medical privacy laws.

(5) Utilization review evaluations must use generally accepted standards for treatment of the

illness, injury, or condition that is being reviewed.

(6) Utilization review opinions must be signed by the health care professional performing the review.

(7) A utilization review organization may not base its fees or charges on any recommendation for a reduction in payment under an insurance contract or on a percentage of claim savings."

Section 36. Section 33-33-202, MCA, is amended to read:

"33-33-202. Standards for property and casualty insurers. (1) Property or casualty insurers seeking utilization reviews with respect to insurance contracts issued in this state may use only utilization review organizations that are registered under 33-33-201 meet the requirements of this part and any rules adopted pursuant to this part.

(2) A property or casualty insurer is responsible for:

(a) monitoring all utilization review activities carried out by or on behalf of the property or casualty insurer;

(b) ensuring that all requirements of this part and rules adopted pursuant to this part are met; and

(c) ensuring that appropriate personnel have operational responsibility for and oversight of the performance of the property or casualty insurer's utilization review program and contracts with utilization review organizations.

~~(2)~~(3) A property or casualty insurer that denies, in whole or in part, a policyholder's claim after consideration of a utilization review shall provide the policyholder an opportunity to request reconsideration by the insurer and the opportunity to submit additional information relating to the claim."

Section 37. Coverage of oral therapy -- opioid use disorder. A health insurance issuer may not impose prior authorization or step therapy requirements for an oral therapy prescription used to treat opioid use disorder.

Section 38. Section 33-36-102, MCA, is amended to read:

"33-36-102. Purpose. The purpose and intent of this chapter are to:

- (1) establish standards for the creation and maintenance of networks by health carriers offering managed care plans and to ensure the adequacy, accessibility, and quality of health care services offered under a managed care plan by establishing requirements for written agreements between health carriers offering managed care plans and participating providers regarding the standards, terms, and provisions under which the participating provider will provide services to covered persons;
- (2) provide for the implementation of state network adequacy and quality assurance standards in administrative rules, provide for monitoring compliance with those standards, and provide a mechanism for detecting and reporting violations of those standards to the commissioner;
- (3) establish minimum criteria for the quality assessment activities of a health carrier issuing a closed plan or a combination plan and to require that minimum state quality assessment criteria be adopted by rule;
- (4) enable health carriers to evaluate, maintain, and improve the quality of health care services provided to covered persons; and
- (5) provide a streamlined and simplified process by which managed care network adequacy and quality assurance programs may be monitored for compliance through ~~coordinated efforts of~~ by the commissioner ~~and the department~~. It is not the purpose or intent of this chapter to apply quality assurance standards applicable to medicaid or medicare to managed care plans regulated pursuant to this chapter or to create or require the creation of quality assurance programs that are as comprehensive as quality assurance programs applicable to medicaid or medicare."

Section 39. Section 33-36-103, MCA, is amended to read:

"33-36-103. Definitions. As used in this chapter, the following definitions apply:

- (1) "Closed plan" means a managed care plan that requires covered persons to use only participating providers under the terms of the managed care plan.
- (2) "Combination plan" means an open plan with a closed component.
- (3) "Covered benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.
- (4) "Covered person" means a policyholder, subscriber, or enrollee or other individual participating

in a health benefit plan.

~~(5)~~ "Department" means the department of public health and human services established in 2-15-2201.

~~(6)~~(5) "Emergency medical condition" means a condition manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- (a) the covered person's health would be in serious jeopardy;
- (b) the covered person's bodily functions would be seriously impaired; or
- (c) a bodily organ or part would be seriously damaged.

~~(7)~~(6) "Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

~~(8)~~(7) "Facility" means an institution providing health care services or a health care setting, including but not limited to a hospital, medical assistance facility, or critical access hospital, as defined in 50-5-101, or other licensed inpatient center, an outpatient center for surgical services, a treatment center, a skilled nursing center, a residential treatment center, a diagnostic laboratory, a diagnostic imaging center, or a rehabilitation or other therapeutic health setting.

~~(9)~~(8) "Health benefit plan" means a policy, contract, certificate, or agreement entered into, offered, or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

~~(10)~~(9) "Health care professional" means a physician or other health care practitioner licensed, accredited, or certified pursuant to the laws of this state to perform specified health care services consistent with state law.

~~(11)~~(10) "Health care provider" or "provider" means a health care professional or a facility.

~~(12)~~(11) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

~~(13)~~(12) "Health carrier" means an entity subject to the insurance laws and rules of this state that contracts, offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a disability insurer, health maintenance organization, or

health service corporation or another entity providing a health benefit plan.

~~(14)~~(13) "Intermediary" means a person authorized to negotiate, execute, and be a party to a contract between a health carrier and a provider or between a health carrier and a network.

~~(15)~~(14) "Managed care plan" means a health benefit plan that either requires or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with, or employed by a health carrier, but not preferred provider organizations or other provider networks operated in a fee-for-service indemnity environment.

~~(16)~~(15) "Medically necessary" means services, medicines, or supplies that are necessary and appropriate for the diagnosis or treatment of a covered person's illness, injury, or medical condition according to accepted standards of medical practice and that are not provided only as a convenience.

~~(17)~~(16) "Network" means the group of participating providers that provides health care services to a managed care plan.

~~(18)~~(17) "Open plan" means a managed care plan other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan.

~~(19)~~(18) "Participating provider" means a provider who, under a contract with a health carrier or with the health carrier's contractor, subcontractor, or intermediary, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health carrier.

~~(20)~~(19) "Primary care professional" means a participating health care professional designated by the health carrier to supervise, coordinate, or provide initial care or continuing care to a covered person and who may be required by the health carrier to initiate a referral for specialty care and to maintain supervision of health care services rendered to the covered person.

~~(21)~~(20) "Quality assessment" means the measurement and evaluation of the quality and outcomes of medical care provided to individuals, groups, or populations.

~~(22)~~(21) "Quality assurance" means quality assessment and quality improvement.

~~(23)~~(22) "Quality improvement" means an effort to improve the processes and outcomes related to the provision of health care services within a health plan."

Section 40. Section 33-36-105, MCA, is amended to read:

"33-36-105. ~~Department Commissioner~~ -- general powers and duties -- rulemaking. (1) The ~~department commissioner~~ shall:

(a) adopt rules pursuant to the Montana Administrative Procedure Act establishing minimum state standards for network adequacy and quality assurance and procedures for ensuring compliance with those standards; and

(b) ~~recommend action to the commissioner~~ if appropriate, initiate action against a health carrier whose managed care plan does not comply with standards for network adequacy and quality assurance adopted by the ~~department commissioner~~.

(2) Quality assurance standards adopted by the ~~department commissioner~~ must consist of some but not all of the health plan employer data and information standards. The ~~department commissioner~~ shall select and adopt only standards appropriate for quality assurance in Montana.

(3) The state may contract, through a competitive bidding process, for the development of network adequacy and quality assurance standards."

Section 41. Section 33-36-201, MCA, is amended to read:

"33-36-201. Network adequacy -- standards -- access plan required. (1) A health carrier offering a managed care plan in this state shall maintain a network that is sufficient in numbers and types of providers to ensure that all services to covered persons are accessible without unreasonable delay. Sufficiency in number and type of provider is determined in accordance with the requirements of this section. Covered persons must have access to emergency care 24 hours a day, 7 days a week. A health carrier providing a managed care plan shall use reasonable criteria to determine sufficiency. The criteria may include but are not limited to:

- (a) a ratio of specialty care providers to covered persons;
- (b) a ratio of primary care providers to covered persons;
- (c) geographic accessibility;
- (d) waiting times for appointments with participating providers;
- (e) hours of operation; or

(f) the volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.

(2) Whenever a health carrier has an insufficient number or type of participating providers to provide a covered benefit, the health carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the covered benefit were obtained from participating providers or shall make other arrangements acceptable to the ~~department~~ commissioner.

(3) The health carrier shall establish and maintain adequate provider networks to ensure reasonable proximity of participating providers to the businesses or personal residences of covered persons. In determining whether a health carrier has complied with this requirement, consideration must be given to the relative availability of health care providers in the service area under consideration.

(4) A health carrier offering a managed care plan in this state on ~~October 1, 1999~~ January 1, 2024, shall file with the ~~department~~ commissioner on ~~October 1, 1999~~ December 1, 2023, an access plan complying with subsection (6) and the rules of the ~~department~~ commissioner. A health carrier offering a managed care plan in this state for the first time after ~~October 1, 1999~~ January 1, 2024, shall file with the ~~department~~ commissioner an access plan meeting the requirements of subsection (6) and the rules of the ~~department~~ commissioner at least 60 days before offering the managed care plan. A plan must be filed with the ~~department~~ commissioner in a manner and form complying with the rules of the ~~department~~ commissioner. A health carrier shall file any subsequent material changes in its access plan with the ~~department~~ commissioner within at least 30 days prior to ~~of~~ implementation of the change.

(5) A health carrier may request the ~~department~~ commissioner to designate parts of its access plan as proprietary or competitive information, and when designated, that part may not be made public. For the purposes of this section, information is proprietary or competitive if revealing the information would cause the health carrier's competitors to obtain valuable business information. A health carrier shall make the access plans, absent proprietary information, available on its business premises and shall provide a copy of the plan upon request.

(6) An access plan for each managed care plan offered in this state must describe or contain at least the following:

(a) a listing of the names and specialties of the health carrier's participating providers;

- (b) the health carrier's procedures for making referrals within and outside its network;
 - (c) the health carrier's process for monitoring and ensuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in the managed care plan;
 - (d) the health carrier's efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;
 - (e) the health carrier's methods for assessing the health care needs of covered persons and their satisfaction with services;
 - (f) the health carrier's method of informing covered persons of the plan's services and features, including but not limited to the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care;
 - (g) the health carrier's system for ensuring the coordination and continuity of care for covered persons referred to specialty physicians and for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;
 - (h) the health carrier's process for enabling covered persons to change primary care professionals;
 - (i) the health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and a participating provider or in the event of the health carrier's insolvency or other inability to continue operations. The description must explain how covered persons will be notified of the contract termination or the health carrier's insolvency or other cessation of operations and be transferred to other providers in a timely manner.
 - (j) any other information required by the ~~department~~commissioner to determine compliance with this part and the rules implementing this part.
- (7) The ~~department~~commissioner shall ensure timely and expedited review and approval of the access plan and other requirements in this section."

Section 42. Section 33-36-203, MCA, is amended to read:

"33-36-203. Selection of providers -- professional credentials standards. (1) A health carrier shall adopt standards for selecting participating providers who are primary care professionals and for each health

care professional specialty within the health carrier's network. The health carrier shall use the standards to select health care professionals, the health carrier's intermediaries, and any provider network with which the health carrier contracts. A health carrier may not adopt selection criteria that allow the health carrier to:

(a) avoid high-risk populations by excluding a provider because the provider is located in a geographic area that contains populations or providers presenting a risk of higher than average claims, losses, or use of health care services; or

(b) exclude a provider because the provider treats or specializes in treating populations presenting a risk of higher than average claims, losses, or use of health care services.

(2) Subsection (1) does not prohibit a health carrier from declining to select a provider who fails to meet the other legitimate selection criteria of the health carrier adopted in compliance with this part and the rules implementing this part.

(3) This part does not require a health carrier, its intermediary, or a provider network with which the health carrier or its intermediary contract to employ specific providers or types of providers who may meet their selection criteria or to contract with or retain more providers or types of providers than are necessary to maintain an adequate network.

(4) A health carrier may use criteria established in accordance with the provisions of this section to select health care professionals allowed to participate in the health carrier's managed care plan. A health carrier shall make its selection standards for participating providers available for review by the department commissioner and by each health care professional who is subject to the selection standards."

Section 43. Section 33-36-209, MCA, is amended to read:

"33-36-209. Use of intermediaries -- responsibilities of health carriers, intermediaries, and providers. (1) A health carrier is responsible for complying with applicable provisions of this chapter, and contracting with an intermediary for all or some of the services for which a health carrier is responsible does not relieve the health carrier of responsibility for compliance.

(2) A health carrier may determine whether a subcontracted provider participates in the provider's own network or a contracted network for the purpose of providing covered benefits to the health carrier's covered persons.

(3) A health carrier shall maintain copies of all intermediary health care subcontracts at the health carrier's principal place of business in this state or ensure that the health carrier has access to all intermediary subcontracts, including the right to make copies of the contracts, upon 20 days' prior written notice from the health carrier.

(4) If required in a contract or otherwise by a health carrier, an intermediary shall transmit utilization documentation and claims-paid documentation to the health carrier. The health carrier shall monitor the timeliness and appropriateness of payments made to providers and health care services received by covered persons. This duty may not be delegated to an intermediary by a health carrier.

(5) If required in a contract or otherwise by a health carrier, an intermediary shall maintain the books, records, financial information, and documentation of services provided to covered persons at its principal place of business in the state and preserve them for 5 years in a manner that facilitates regulatory review.

(6) An intermediary shall allow the commissioner ~~and the department~~ access to the intermediary's books, records, claim information, billing information, and other documentation of services provided to covered persons that are required by any of those entities to determine compliance with this part and the rules implementing this part.

(7) A health carrier may, in the event of the intermediary's insolvency, require the assignment to the health carrier of the provisions of a participating provider's contract addressing the participating provider's obligation to furnish covered benefits."

Section 44. Section 33-36-210, MCA, is amended to read:

"33-36-210. Contract filing requirements -- material changes -- state access to contracts. (1) A health carrier offering a managed care plan in this state on January 1, 2024, shall file with the commissioner ~~on October 1, 1999~~ December 1, 2023, a health carrier offering a managed care plan shall file with the ~~department~~ sample contract forms proposed for use with its participating providers and intermediaries. A health carrier offering a managed care plan in this state for the first time after January 1, 2024, shall file with the commissioner sample contract forms proposed for use with its participating providers and intermediaries at least 60 days before offering the managed care plan.

(2) A health carrier shall file with the ~~department~~commissioner a material change to a contract.

The change must be filed with the ~~department~~commissioner at least 60 days before use of the proposed change. A change in a participating provider payment rate, coinsurance, copayment, or deductible or other plan benefit is not considered a material change for the purpose of this subsection.

(3) A health carrier shall maintain participating provider and intermediary contracts at its principal place of business in this state, or the health carrier must have access to all contracts and provide copies to the ~~department~~commissioner ~~upon~~on 20 days' prior written notice from the ~~department~~commissioner."

Section 45. Section 33-36-211, MCA, is amended to read:

"33-36-211. General contracting requirements. (1) The execution of a contract for health care services with an intermediary by a health carrier does not relieve the health carrier of its duty to provide health care services to a person with whom the health carrier has contracted and does not relieve the health carrier of its responsibility for compliance with this chapter or the rules implementing this chapter.

(2) All contracts by a health carrier for the provision of health care services by a managed care plan must be in writing and are subject to review by the ~~department and the~~ commissioner."

Section 46. Section 33-36-212, MCA, is amended to read:

"33-36-212. Contract compliance dates. ~~(1)~~A contract between a health carrier and a participating provider or intermediary ~~in effect on October 1, 1999,~~ must comply with this part and the rules implementing this part on the date the contract is issued or put into effect by October 1, 1999. ~~The department may extend the October 1 date for an additional period of up to 6 months if the health carrier demonstrates good cause for an extension.~~

~~(2)~~ A contract between a health carrier and a participating provider or intermediary issued or put into effect ~~on or after October 1, 1999,~~ must comply with this part and the rules implementing this part on the day that it is issued or put into effect.

~~(3)~~ A contract between a health carrier and a participating provider or intermediary not described in subsection (1) or (2) must comply with this part and the rules implementing this part by October 1, 1999."

Section 47. Section 33-36-213, MCA, is amended to read:

"33-36-213. Department rules Rulemaking authority. The ~~department~~commissioner may adopt rules to implement this part."

Section 48. Section 33-36-301, MCA, is amended to read:

"33-36-301. Quality assurance -- national accreditation. (1) A health carrier whose managed care plan has been accredited by a nationally recognized accrediting organization shall annually provide a copy of the accreditation and the accrediting standards used by the accrediting organization to the ~~department~~commissioner.

(2) If the ~~department~~commissioner finds that the standards of a nationally recognized accrediting organization meet or exceed state standards and that the health carrier has been accredited by the nationally recognized accrediting organization, the ~~department~~commissioner shall approve the quality assurance standards of the health carrier.

(3) The ~~department~~commissioner shall maintain a list of accrediting organizations whose standards have been determined by the ~~department~~commissioner to meet or exceed state quality assurance standards.

(4) Section 33-36-302 does not apply to a health carrier's managed care plan if the health carrier maintains current accreditation by a nationally recognized accrediting organization whose standards meet or exceed state quality assurance standards adopted pursuant to this part.

(5) This section does not prevent the ~~department~~commissioner from monitoring a health carrier's compliance with this part."

Section 49. Section 33-36-302, MCA, is amended to read:

"33-36-302. Standards for health carrier quality assessment programs. A health carrier that issues a closed plan or a combination plan shall adopt and use infrastructure and disclosure systems sufficient to accurately measure the quality of health care services provided to covered persons on a regular basis and appropriate to the types of plans offered by the health carrier. To comply with this requirement, a health carrier shall:

- (1) establish and use a system designed to assess the quality of health care provided to covered persons and appropriate to the types of plans offered by the health carrier. The system must include systematic collection, analysis, and reporting of relevant data.
- (2) communicate in a timely fashion its findings concerning the quality of health care to regulatory agencies, providers, and consumers as provided in 33-36-304;
- (3) report to the appropriate professional or occupational licensing board provided in Title 37 any persistent pattern of problematic care provided by a participating provider that is sufficient to cause the health carrier to terminate or suspend a contractual arrangement with the participating provider; and
- (4) file a written description of the quality assessment program and any subsequent material changes with the ~~department~~ commissioner in a format that must be prescribed by rules of the ~~department~~ commissioner. The description must include a signed certification by a corporate officer of the health carrier that the health carrier's quality assessment program meets the requirements of this part."

Section 50. Section 33-36-303, MCA, is amended to read:

"33-36-303. Standards for health carrier quality improvement programs. A health carrier that issues a closed plan or a combination plan shall, in addition to complying with 33-36-302, adopt and use systems and methods necessary to improve the quality of health care provided in the health carrier's managed care plan as indicated by the health carrier's quality assessment program and as required by this section. To comply with this requirement, a health carrier subject to this section shall:

- (1) establish an internal system capable of identifying opportunities to improve care;
- (2) use the findings generated by the system required by subsection (1) to work on a continuing basis with participating providers and other staff within the closed plan or closed component to improve the health care delivered to covered persons; and
- (3) consistent with this part, adopt and use a program for measuring, assessing and improving the outcomes of health care as identified in the health carrier's quality improvement program plan and provide at the commissioner's request a current quality improvement program plan. ~~This quality improvement program plan must be filed with the department by October 1, 2000, and must be consistent with this part. A health carrier shall file any subsequent material changes to its quality improvement program plan within 30 days of~~

~~implementation of the change.~~The quality improvement program plan must:

- (a) implement improvement strategies in response to quality assessment findings that indicate improvement is needed; and
- (b) evaluate, not less than annually, the effectiveness of the strategies implemented pursuant to subsection (3)(a)."

Section 51. Section 33-36-304, MCA, is amended to read:

"33-36-304. Reporting and disclosure requirements. (1) A health carrier offering a closed plan or a combination plan shall document and communicate information, as required in this section, about its quality assurance program. The health carrier shall:

- (a) include a summary of its quality assurance program in marketing materials;
- (b) include a description of its quality assurance program and a statement of patient rights and responsibilities with respect to that program in the certificate of coverage or handbook provided to newly enrolled covered persons; and
- (c) make available annually to providers and covered persons a report containing findings from its quality assurance program and information about its progress in meeting internal goals and external standards, when available.

(2) A health carrier shall certify to the ~~department~~ commissioner annually that its quality assurance program and the materials provided to providers and consumers in accordance with subsection (1) meet the requirements of this part.

(3) A health carrier shall make available, upon request and payment of a reasonable fee, the materials certified pursuant to subsection (2), except for the materials subject to the confidentiality requirements of 33-36-305 and materials that are proprietary to the managed care plan. A health carrier shall retain all certified materials for at least 3 years from the date that the material was certified or until the material has been examined as part of a market conduct examination, whichever is later."

Section 52. Section 33-36-305, MCA, is amended to read:

"33-36-305. Confidentiality of health care and quality assurance records -- disclosure. (1)

Except as provided in subsection (2), the following information held by a health carrier offering a closed plan or a combination plan is confidential and may not be disclosed by the carrier to a person:

(a) information pertaining to the diagnosis, treatment, or health of a covered person, regardless of whether the information is in the form of paper, is preserved on microfilm, or is stored in computer-retrievable form;

(b) information considered by a quality assurance program and the records of its actions, including testimony of a member of a quality committee, of an officer, director, or other member of a health carrier or its staff engaged in assisting the quality committee or engaged in the health carrier's quality assessment, quality improvement, or quality assurance activities, or of any person assisting or furnishing information to the quality committee.

(2) The information specified in subsection (1) may be disclosed:

(a) as allowed by Title 33, chapter 19;

(b) as required in proceedings before the commissioner, a professional or occupational licensing board provided in Title 37, or the department of public health and human services pursuant to Title 50, chapter 5, part 2;

(c) in an appeal, if an appeal is permitted, from a quality committee's findings or recommendations;
or

(d) as otherwise required by law or court order, including a judicial or administrative subpoena.

(3) Information specified in subsection (1) identifying:

(a) the provider may also be disclosed upon a written, dated, and signed approval of the provider if the information does not identify the covered person;

(b) the covered person may also be disclosed upon a written, dated, and signed approval of the covered person or of the parent or guardian of a covered person if the covered person is a minor and if the information does not identify the provider;

(c) neither the provider nor the covered person may also be disclosed upon request for use for statistical purposes only."

Section 53. Section 33-36-401, MCA, is amended to read:

"33-36-401. Enforcement. (1) If the ~~department~~commissioner determines that a health carrier has not complied with this chapter or the rules implementing this chapter, the ~~department~~commissioner may recommend corrective action to the health carrier.

(2) ~~At the recommendation of the department the~~ The commissioner may take an enforcement action provided in subsection (3) if:

(a) a health carrier fails to implement corrective action recommended by the ~~department~~commissioner;

(b) corrective action taken by a health carrier does not result in bringing a health carrier into compliance with this chapter and the rules implementing this chapter within a reasonable period of time;

(c) ~~the department demonstrates to the commissioner that~~ a health carrier does not comply with this chapter or the rules implementing this chapter; or

(d) the commissioner determines that a health carrier has violated or is violating this chapter or the rules implementing this chapter.

(3) The commissioner may take any of the following enforcement actions to require a health carrier to comply with this chapter or the rules implementing this chapter:

(a) suspend or revoke the health carrier's certificate of authority or deny the health carrier's application for a certificate of authority; or

(b) use any of the commissioner's other enforcement powers provided in Title 33, chapter 1, part 3."

Section 54. Repealer. The following sections of the Montana Code Annotated are repealed:

33-2-322. Surplus lines advisory organization -- consultation with commissioner in developing approved risk list.

33-7-123. Commissioner as agent -- service of process -- procedure -- fee.

33-17-405. Service of process -- commissioner as agent.

Section 55. Transition. The department of public health and human services and the state auditor are authorized to transfer existing rules that implement the Managed Care Plan Network Adequacy and Quality

Assurance Act, Title 33, chapter 36, to implement the provisions of [this act].

Section 56. Codification instruction. (1) [Section 8] is intended to be codified as an integral part of Title 33, chapter 2, part 3, and the provisions of Title 33, chapter 2, part 3, apply to [section 8].

(2) [Section 13] is intended to be codified as an integral part of Title 33, chapter 7, part 1, and the provisions of Title 33, chapter 7, part 1, apply to [section 13].

(3) [Section 17] is intended to be codified as an integral part of Title 33, chapter 17, part 4, and the provisions of Title 33, chapter 17, part 4, apply to [section 17].

(4) [Section 37] is intended to be codified as an integral part of Title 33, chapter 22, part 1, and the provisions of Title 33, chapter 22, part 1, apply to [section 37].

Section 57. Effective dates. (1) Except as provided in subsections (2), (3), and (4), [this act] is effective October 1, 2023.

(2) [Sections 2, 3, 4, 6, 8, 9, 13, 14, 15, 16, 17, 18, 20, 21, 22, 31, 35, 36, 37, 41, and 43] and this section are effective on passage and approval.

(3) [Section 33] is effective January 1, 2025.

(4) [Sections 38 through 40 and sections 42 through 53] are effective January 1, 2024.

Section 58. Applicability. [Section 6] applies to offenses that occur on or after [the effective date of this act].

- END -

I hereby certify that the within bill,
HB 156, originated in the House.

Chief Clerk of the House

Speaker of the House

Signed this _____ day
of _____, 2023.

President of the Senate

Signed this _____ day
of _____, 2023.

HOUSE BILL NO. 156

INTRODUCED BY E. BUTTREY

BY REQUEST OF THE STATE AUDITOR

AN ACT GENERALLY REVISING LAWS UNDER THE SUPERVISION OF THE STATE AUDITOR; REVISING SECURITIES LAWS RELATING TO DISCLOSURE OF FINANCIAL EXPLOITATION OF AN OLDER PERSON; AUTHORIZING THE SECURITIES ASSISTANCE RESTITUTION FUND TO ASSERT CERTAIN CLAIMS FOR RESTITUTION; REVISING LAWS RELATING TO COMMISSIONER ACCESS TO INSURANCE RECORDS; REVISING INSURANCE LAWS TO REMOVE CERTAIN SERVICE OF PROCESS FEES; REVISING INSURANCE SERVICE OF PROCESS LAWS; REVISING INSURANCE CERTIFICATE OF AUTHORITY LAWS; REQUIRING THE COMMISSIONER TO MAKE AN APPROVED RISK LIST; REVISING THE PENALTY RELATING TO CERTAIN SURPLUS LINES FILINGS; DEFINING PHARMACY SERVICES ADMINISTRATIVE ORGANIZATION; REVISING LAWS RELATING TO PHARMACY SERVICES ADMINISTRATIVE ORGANIZATIONS; REVISING LAWS RELATING TO FILINGS OF POLICY FORMS; REVISING LAWS RELATING TO THE APPOINTMENT OF FOREIGN OR ALIEN SOCIETIES; REVISING LAWS RELATING TO THE BOARD OF DIRECTORS OF THE MONTANA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION BOARD; REVISING LAWS RELATING TO COMMERCIAL LINES POLICIES; REVISING LAWS RELATING TO THE FILING OF VARIABLE LIFE INSURANCE CONTRACTS; REVISING PHARMACY SERVICES ADMINISTRATIVE ORGANIZATION LAWS; REVISING DEFINITIONS; REVISING LAWS RELATING TO THE MONTANA REINSURANCE ASSOCIATION ACT; ALLOWING THE COMMISSIONER TO PERFORM DUTIES OF THE ASSOCIATION ADMINISTRATOR; REVISING MONTANA REINSURANCE ASSOCIATION BOARD POWERS AND COMMISSIONER DUTIES; REVISING LAWS RELATED TO REINSURANCE ASSOCIATION REIMBURSEMENT, PAYMENT, AND EXPENSES; DEFINING "TITLE GUARANTEE"; AUTHORIZING THE COMMISSIONER TO ORDER RESTITUTION RELATED TO TITLE INSURANCE; REVISING LAWS RELATING TO IN-NETWORK AND OUT-OF-NETWORK EMERGENCY SERVICES; REVISING LAWS RELATED TO UTILIZATION REVIEW ORGANIZATIONS; REVISING LAWS RELATED TO STANDARDS FOR PROPERTY AND CASUALTY INSURERS; PROVIDING FOR COVERAGE OF CERTAIN ORAL THERAPY PRESCRIPTIONS RELATED TO OPIOID USE DISORDERS; TRANSFERRING

STATUTORY DUTIES FROM THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES TO THE COMMISSIONER OF SECURITIES AND INSURANCE RELATING TO THE MANAGED CARE PLAN NETWORK ADEQUACY AND QUALITY ASSURANCE ACT; AUTHORIZING THE COMMISSIONER TO TRANSFER EXISTING RULES RELATING TO THE ACT; EXTENDING RULEMAKING AUTHORITY; AMENDING SECTIONS 15-31-114, 30-10-341, 30-10-1004, 33-1-408, 33-1-605, 33-1-1502, 33-2-116, 33-2-312, 33-2-2402, 33-2-2404, 33-4-509, 33-7-531, 33-10-204, 33-15-336, 33-17-1101, 33-20-606, 33-20-1304, 33-20-1316, 33-22-156, 33-22-170, 33-22-172, 33-22-173, 33-22-177, 33-22-1128, 33-22-1303, 33-22-1307, 33-22-1308, 33-22-1309, 33-22-1313, 33-22-1314, 33-22-1315, 33-22-1316, 33-22-1317, 33-22-1321, 33-23-310, 33-25-105, 33-25-301, 33-31-201, 33-32-215, 33-33-102, 33-33-201, 33-33-202, 33-36-102, 33-36-103, 33-36-105, 33-36-201, 33-36-203, 33-36-209, 33-36-210, 33-36-211, 33-36-212, 33-36-213, 33-36-301, 33-36-302, 33-36-303, 33-36-304, 33-36-305, AND 33-36-401, MCA; REPEALING SECTIONS 33-2-322, 33-7-123, AND 33-17-405, MCA; AND PROVIDING EFFECTIVE DATES AND AN APPLICABILITY DATE.